WHITE PAPER

EVALUATING VARIOUS INCENTIVES
DELIVERABLE #6

OCCUPATIONAL HEALTH SERVICES PILOT PROJECT

Draft: February 5, 2001

Introduction

Research in previous white papers looked at the current state–of-the-art treatment of injured workers in occupational medicine. The papers identified specific strengths and weaknesses in the prevention and treatment of work place injuries in Washington State. In particular, the white paper on enhancing attending physician occupational health expertise identified current best practices in the treatment of injured workers. It also identified seven key indicators of provider behavior that affect a reduction in long-term disability from injury, encourage identification and correction of the cause of injuries, and enable safe return to work. The white paper on service and care coordination identified that Washington physicians who treat injured workers are less likely to perform certain key steps in care management for injured workers than best practices would indicate. The white paper also identified a role for the Centers of Occupational Health and Education(COHE) and pilot physicians. The white paper on quality assurance identified the measures to be used to assure high quality results from both groups.

This white paper evaluates and proposes incentives, both financial and non-financial, to encourage the desired behaviors outlined in the previous white papers. Particular emphasis is given to those behaviors outlined in the white paper on quality assurance.

Purpose

The purpose of this deliverable is to evaluate possible models for incentives, both financial and non-financial, for pilot providers, the COHEs , and employers within the pilot program. This deliverable will look at traditional incentives such as fees paid for common medical services. It will also explore other possible incentives or disincentives that will focus on ways to optimize occupational health practice patterns for providers, workers, and employers. This paper will not reevaluate the current fee schedule, but will look at providing compensation for certain activities.

The objective of the recommended incentives will be to encourage community participation in the pilot COHEs. Another objective of the recommended incentives is to provide motivation for providers to move closer to the desired state of occupational health expertise described in the project white papers. These incentives will focus on the seven key indicators of physician behavior that have been shown to reduce long-term disability from injury, encourage identification and correction of the cause of injuries, and enable safe return to work. Those seven indicators are:

1. Notification of the employer of worker injury.
2. Use of treatment protocols and guidelines.
3. Use of standardized work restrictions.
4. Ability to identify job (ergonomic) risks.
5. Ability to perform case management.
6. Specification of work restrictions rather than removal from work when an injured employee is unable to perform his or her regular job.
7. Use of specialized occupational medicine information systems.

Additional incentives can be based upon the quality indicators that are being developed based upon research completed at the University of Washington.[1] Possible candidates for inclusion in the pilot program might be:

- Completion of required medical documentation
- Communication with employers
- Adherence to desired treatment patterns
- Patterns of referrals to specialists and therapists

The recommendations in this white paper are based on:

- The recommendations and outcomes identified in the previous white papers.

- Original survey results from twenty-three occupational medicine programs throughout the United State that were identified as providing excellent occupational medical care.

- Results from a second survey of the same twenty-three occupational medicine programs throughout the United States that were identified as providing excellent occupational medical care. This second survey focused on financial incentives.

- Review of results of L&I's previous research on occupational delivery systems. Review of the Medical Aid Rules and Fee Schedules.

[1] Taken from Carpal Tunnel and Low Back quality indicators under development by University of Washington for Washington Labor and Industries.

- Review of scientific literature regarding physician practice performance standards, workers' compensation fee schedules, and other relevant topics.

- Review of approved AMA codes for services.

- Analysis of Financial and Actuarial information provided by the Department of Labor and Industries[2].

- Review of current national programs specific to employer safety programs.

- Review of current model used in Ohio for reimbursement to Occupational Health Clinics for case management.

- Draft quality indicators for carpal tunnel syndrome, low back sprains and fractures of the upper and lower extremities developed by a University of Washington research team.

What is the current state?

Washington State implemented a resource-based relative value scale (RBRVS) payment methodology for its fee schedule in 1993. The fee schedules and reimbursement policies are listed in the Medical Aid Rules and Fee Schedules. The medical fee schedule uses CPT-4 codes to identify procedures. It was last updated January 1, 1998. It has been reported by Labor and Industries that in an effort to improve timeliness of reporting injuries, Washington is in the process of developing a web based Report of Accident to be implemented for filing electronic reports early in 2001.

Currently, Washington has department-specific codes that are used for unique services. Washington is unusual in that the Department of Labor and Industries reimburses the attending physician for the completion of forms that are included in the treatment fees in other states.[3] [4] These forms include the following:

- Attending physician final report
- Loss of earning power
- Review of job analysis by attending provider

[2] Data provided by the Department of Labor and Industries under a file containing Total and Medical Aid Fund Paid and Incurred Losses and accident Fund Incurred and Paid Losses

[3] *Attending Doctor's Handbook*, Washington State Department of Labor & Industries 1999, p. 22 B. Reports and Documentation

[4] *Washington RBRVS Payment Policies*, Washington State Department of Labor & Industries July 1, 2000, p. 166-167

- Employer requested physical restrictions
- Report of industrial injury
- Reopening application form
- Doctors estimate of physical capacities
- Copies of records
- Occupational History Form
- Supplemental Medical Report

What is the desired future state?

The desired future state is to create and test prototype financial and non-financial incentives. These incentives should provide motivation for providers to adopt practice strategies that improve the outcomes in delivering healthcare to injured workers. These incentives will be focused on quality treatment and outcomes specific to the pilot program outlined in previous white papers and the University of Washington quality indicators.

The results of the pilot must be measured by improving quality of treatment without creating a risk for the financial integrity of the system. To this end, one measurement of the success or failure of the pilot program will be based upon the ability to implement the financial-based incentives without driving the claims costs up in the absence of any other measurable benefits. To this end, the financial analysis of the pilot should include an understanding of the paid and incurred losses before the implementation of the project compared to paid and incurred losses after the pilot project. These costs should be stratified based on geographic region, medical inflation, manual classification and changes in claim benefits.

The analysis of past and future losses should include a reporting of trends in the incidence of injury, duration of time loss, length of treatment to medical recovery, and overall average claim costs. To complete the analysis of the success of the project, these same indicators applied to cases that are treated outside of the pilot program and those outcomes compared to the outcomes reported in the pilot project. Details of the recommended financial analysis are provided in Appendix C.

What are the best ways to achieve the desired future state?

The financial and non-financial incentives have been broken down into three distinct groups. There are incentives specific to the pilot providers, COHEs and employers. A summary of the pilot incentives are included in Appendix D.

Pilot Providers Incentives

White paper two[5] identified Stage 4 occupational health delivery systems that represent the state-of-the-art. Stage 4 systems stratify providers based upon providers' use of practice standards and treatment guidelines. Those providers who comply are freed from pre-authorization requirements for treatment in accepted claims. It will be the role of the COHE to identify these providers in their community.

In addition, the pilot providers will be asked to comply with certain improvements in timeliness and paperwork accuracy. This will reduce inefficiencies in the system and provide improved treatment to injured workers.

The challenge is to provide incentives for new behaviors in the physician community. Positive incentives are the focus of the paper instead of disincentives. Due to the voluntary and pilot nature of the project there is a concern that disincentives could result in providers choosing not to participate in the pilot.

Financial Incentives

Timeliness of the Report of Accident is essential to the overall success of the injury management process. In Washington, the average length of time between medical treatment and the claim being received by Labor and Industries is 11 days.[6] In order for care coordination to begin, the treating physician must notify the COHE or L&I of the worker injury in a more timely fashion (possibly electronically).

Currently, Washington compensates the treating physician for completing the Accident Report through the use of department billing codes and fees. It is recommended that those physicians in the pilot that report the injury electronically within the first 24 hours of treatment to the COHE receive an additional payment per case for timely reporting. This electronic reporting of the injury may be accomplished either through completion of the ROA on a web-based form as is currently under development or through a fax transmission of the completed ROA. These additional payments would be paid through billing codes developed by L & I. Research for this white paper only uncovered a couple of states that reimburse for form completion and none that pay for timely completion of those forms.[7] [8] [9] This incentive will serve the dual purpose of improving timeliness but also efficiency for the

[5] Occupational Health Services Pilot Project, White Paper on Service and Care Coordination Deliverable #2, p. 10 Appendix A
[6] Data provided by Department of Labor and Industries under a file named timetopayoutcome.xls
[7] Texas Sate regulations referenced from www.twcc.state.tx.us
[8] California State regulations referenced from www.dir.ca.gov/dwc
[9] Ohio State Regulations referenced from www.ohiobwc.com

Department of Labor and Industries by eliminating much of the manual processing, scanning, and imaging of the First Report of Accident.[10]

All of the physicians within the pilot should be required to provide the injured worker, employer, and care coordinator with a treatment summary form on discharge from each visit that outlines the physical capabilities of the injured worker and any changes in treatment plan, diagnosis, or prognosis. It is recommended that the physicians in the pilot be paid for the compilation of this form through fee codes developed by L & I. Currently, Washington payment policies allow for an Employer Requested PCE/Physical Restrictions[11] report if authorized by the employer. This billing code could be used without the need for a request from the employer, as an alternative to creating a new fee code. Implementation of this form and reimbursement would be done in accordance with the process described in the white paper on clinical information management.[12]

It is also suggested that providers be offered incentives that would enhance and improve patient education. Education falls into the patterns of behavior that are identified in the quality indicators that are being developed by L&I and The University of Washington.[13] There are CPT codes available for compensation for patient education activities. It is recommended that L&I develop a payment schedule for at least some base level of patient education, identifying appropriate CPT codes that the treating provider and COHE could use to receive compensation for those services. This will also provide an avenue for L&I to track those providers who are more active in the patient education process and to consider including patient education as one of the behavior patterns used to identify those providers who will receive access to additional incentives (see additional comments in the non-financial incentives section below).

Non-Financial Incentives

It is anticipated that, initially, many providers within the geographic region will want to participate in the pilot project. It is not suggested that any effort be made to screen out willing providers based upon past performance criteria since there is a lack of data on provider profiling in workers' compensation.[14] Attempting to either exclude some providers or stratify providers in the absence of data would, at best, be controversial and complicated and, at worst, could be subject to legal challenge. At the same time, however, it will

[10] Occupational Health Services Pilot Project, Administrative Information and Communication Processes Deliverable #4 , p. 3

[11] *Washington RBRVS Payment Policies,* Washington State Department of Labor & Industries July 1, 2000, p. 166

[12] Occupational Health Services Pilot Project, Clinical Information and Communication Processes. Deliverable #5

[13] Taken from Carpal Tunnel and Low Back quality indicators under development by University of Washington for Washington Labor and Industries.

[14] Workers' Compensation Research Institute publication: Review, Regulate, or Reform? What Works to Control Workers' Compensation Medical Costs? Thomas W. Grannemann, Editor, September 1994; pp 223

be important that Labor and Industries establish at least some initial criteria for participation that outlines minimum training, certification, insurance, and agreement to adhere to program policies and desired best practices.

However, in order to become part of the group that participates in the non-financial incentives, a period of six months of participation in the pilot with demonstration of the desired behaviors identified in Appendix B should be required. Those providers who show the desired behaviors could then be given some designation or ranking such as Silver, Gold, and Platinum and allowed to participate in additional incentives that are reflective of their ranking.

In white paper three, a survey of 186 physicians found that injured worker care was significantly delayed by the authorization process in Washington, as compared to the reported delays in model programs in other states. It is recommended that the pilot providers who demonstrate high quality occupational health care be relieved of some of the administrative burden associated with the workers' compensation claims process and not be required to have prior authorizations for certain services to injured workers. These services could include the following:

- Twenty (20) physical medicine visits including Osteopathic, Chiropractic, and Physical Therapy & Occupational Therapy.
- Diagnostic studies, including x-rays, CAT scans, MRI scans and EMG/NCV.
- Injections up to three soft tissue or joint injections (does not include epidural injections).
- Evaluation and management services and consultation services.

If outcomes and behaviors are to be measured and used in any manner to categorize providers or assign status or rankings it will be very important that the practitioners be given some form of regular feedback on their performance. The data being gathered by the COHE and Labor and Industries should be compiled and used to measure performance and that information should be made easily available to providers either electronically or through a regular report card. This, in effect, creates a feedback loop whereby providers can monitor their own behavior patterns and compare them to the desired standards. It may also encourage participation in the communication process since the data used to measure performance must come from the providers themselves.

There are other intangible incentives to a pilot provider working with the COHE. The close communication between the COHE, the physician, and ultimately the Department of Labor and Industries should result in less paperwork and administrative hassles in approving treatment and processing payments.

Additional consideration should be given to eliminating the requirement for the 60-day report for those providers in the pilot who ultimately comply with communication requirements of the care coordination process and the policies and procedures of the COHE.

COHE Incentives

White paper three identified the responsibilities of the COHE in a state-of-the-art occupational medicine delivery system. The COHE will be responsible for identifying and working with providers committed to national best practice behaviors and implementing a team approach to managing worker injuries with care coordination centralized in the COHE.

Financial Incentives

The COHEs identified and contracted with through this project will be required to be proficient at care coordination and provide some initial quality services from the onset of the contract, as outlined in white paper three.

L&I has indicated that any fees paid are best assigned and paid from the individual claim files. In order to accomplish this, the fees would have to be paid through the established fee schedule. Research for white paper six has indicated that care coordination fees are paid one of two ways; through a fixed case fee (case rate) or fees based on time usage.[15] [16] The recommendation is that care coordination activities are best reimbursed through the use of specific fees for time associated with the activities. This would reimburse more for activities and would cover the costs of care coordination while eliminating the possible complications associated with a diagnosis based tiered case-rate payment model. This would also provide Labor and Industries with an audit trail that is well documented in regard to the care coordination activities of the COHE. For the care coordination, CPT codes for specific activities are recommended. Potential CPT codes that could be used for reimbursement to the COHEs for their activities of care coordination are included in Appendix A.

In addition, white paper three identified specific behaviors that would be required of the COHEs at certain periods of time. Those COHEs that show improvement or accomplishment of those behaviors when expected should be paid for providing performance above the norm. In order to provide this incentive, part of the fees for care coordination should be held in reserve for a performance payment at the end of a predetermined period of measurement. Those that do not meet the performance criteria would not receive the performance payment.

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[15] Initial Survey of Providers Interviews and responses to questions posed to twenty-three Occupational Health Clinic Occupational medicine programs throughout the United States, September 2000

[16] Second Survey of Providers Interviews and responses to questions posed to twenty-three Occupational Health Clinic Occupational medicine programs throughout the United States, December 2000

The beginning performance indicators with an improvement calendar have been provided in white paper three[17]. They are as follows:

1. Notify employer within 24 hours of injured worker visit.
2. Work restrictions are given at each visit.
3. Injured workers are treated using clinical guidelines.
4. Employers offered ergonomic hazard evaluation.
5. Injured workers are seen within 24 hours of seeking an appointment.
6. Patients will be satisfied with care.
7. Employers will be satisfied with care their employees received
8. Sentinel Events will be reviewed.
9. Billing will accurately reflect the care given.
10. Completion of minimum L&I sanctioned continuing education credits.
11. Compliance with Quality Indicators developed by UW research team.
12. Provider education and mentoring

The last item on this list is less tangible as a quantifiable outcome and bears some additional discussion. Linking outcomes and behaviors in Workers' Compensation can be unclear and adjustments for differences in condition severity or comorbidity must be done. But this can be difficult to do accurately and the data must be adjusted for risk. For example, most providers may only see a small number of patients in a given category so there may be a low frequency of adverse effects from care. In some cases, profiling groups of providers and processes of care is likely to be more successful and accurate than profiling of individual providers.[18]

To this end, the performance of the COHE should also be measured, in part, by the performance of the providers who are participants in the pilot within the region. This is reflective of the COHE's role in education and mentoring. A perfect example of this would be provider compliance with electronic reporting within 24 hours. It is not known why some providers do not take advantage of the current payment that is available for completion of the Report of Accident. It is assumed that the reason is, in part, due to a lack of knowledge on the part of the provider and their billing staff regarding their capacity to bill for these services. Therefore, some of the issue associated with delays in reporting may be partially resolved through education efforts on the part of the COHE and L&I. So in this specific example, the

[17] Occupational Health Services Pilot Project, White Paper on Quality Assurance Deliverable 3, p.27 Appendix B

[18] Workers' Compensation Research Institute publication: Review, Regulate, or Reform? What Works to Control Workers' Compensation Medical Costs? Thomas W. Grannemann, Editor, September 1994; pp 227-233

performance of the COHE as an education resource can be partially measured by monitoring the behaviors of providers who agree to work in the pilot project as measured by the average reporting time for the Report of Accident. This same concept can be expanded to other provider outcomes as a way to evaluate the performance of the COHE in regard to the education and mentoring of providers within each region.

All of the COHE performance indicators should be the base line for determining the outstanding performance payment for each individual COHE. A quality improvement workgroup will be reporting on the indicators to the Department of Labor and Industries on a quarterly basis. At the beginning of the contract period the performance indicator acceptable benchmark or target should be set by the workgoup and the Department of Labor and Industries for each quarter, along with the expected improvement. If the COHE meets or surpasses the benchmark or target for each indicator, they will receive 100% of the performance payment. Varying levels of performance can be rewarded on a sliding scale that can be established. The scale would provide less than 100% performance payment for performance that is less than optimal, with a threshold below which none of the performance payment will be given.

Appendix B provides an example of possible performance indicators measurement and a performance payment calculations form.

Non-Financial Incentives

One of the major benefits of becoming a COHE will be the increased community visibility and reputation. Playing a leadership role in the community will set the COHE apart as a leader in the field of occupational health. Providers will look to the COHE as an expert resource.

Another non-financial incentive for the COHEs will be the opportunity for those facilities to have access to state-of-the-art case management information systems if L&I rents or purchases such a system. The white paper on clinical information and communication processes recommended that the COHE be required to use a state-of-the-art case management and patient tracking system. Earlier papers indicated that the use of such systems is common practice within model occupational health providers.[19] Some of the providers who bid on the COHE designation may not currently have access to start-of-the-art systems, and such a designation may represent a significant improvement in their overall operational capacity as an occupational health provider.

[19] Occupational Health Services Pilot Project, White Paper on Clinical Information and Communication Processes Deliverable #5, p.11 Appendix A

Employer Incentives

The employer is an extremely important member of the workers' compensation team. In fact the employer is the team member with the greatest ability to effect the atmosphere after an injury has occurred. Employers possess the greatest opportunity to effect the overall work environment and help prevent injuries from ever occurring. In surveys and personal contact with many different employer groups, one of the biggest hindrances to setting up and maintaining many programs aimed at safety or reduction in compensation costs is financial. Although employers understand that fewer injuries mean lower workers' compensation premiums, the time lag between the expenditure of the money for programs and the premium reduction does not link the outcome to the initial expenditure.

To engage employers as active team members, the Department of Labor and Industries should consider offering the following program as Employer Incentives. This program is designed to focus on the improved safety, is multifaceted, and allows all employers to participate regardless of their size or industry.

Transitional Work Programs

No matter how safe the employer tries to make a work place there are going to be accidents. Recognizing that employers and injured workers have different needs, developing a comprehensive return to work initiative that caters to the unique differences, will effectively reduce the employers' workers' compensation costs while simultaneously lessening the effect on the injured worker[23].

A transitional work program uses the injured workers' actual job duties for a specified amount of time to gradually return the worker to their original job. A true transitional work program has its foundations in the idea that an injured worker can usually perform all or part of their job functions with modifications. The goal is to safely return injured workers back to the job before they are 100% recovered.

This program would result in an additional community service for the COHEs. The COHEs who want to develop the program for the employers should meet specific requirements and be able to demonstrate expertise and prior experience in the on-site transitional work programs to include the availability of an industrial therapist. Providers of the services can be

[23] The Ohio Bureau of Workers' Compensation Drug-Free workplace Program Procedural Guide, February 2000

reimbursed for the onsite services at an hourly rate either paid by the employer or the Department of Labor and Industries.

The employers can be provided incentives to increase participation in the program by having Labor and Industries reimburse the employer for 80% of the development cost up to a maximum cap. The rationale is the 20% out of pocket will be made up in the savings from the decrease in disability payments and the residual expenses of having workers off the job.[24]

An alternative approach to paying for the COHEs services would be to create a specific billing code that the COHE could use whenever they identify a transitional job opportunity with a specific injured worker and go onsite to the employer to develop the plan and facilitate the early return to work. This approach is more of a case-by-case approach rather than the development of a formal plan by the employer. However, with each assessment that the COHE performs a plan can start to emerge so that in the future when other workers are injured and in need of transitional duty, the onsite assessments will be completed and transitional opportunities already identified. Tis approach to funding also has the benefit of linking payment for the plan to specific claims rather than treating it as a special administrative expense.

Job Banking

Transitional duty programs are not always financially practical for many smaller sized employers. Faced with limited resources and a small pool of employees, these employers often cannot afford to accommodate a worker who can only partially complete their job duties while also hiring some form of temporary labor to complete those job functions that the transitional worker is unable to perform. For the small employer this can be equivalent to doubling the production cost of that segment of their business operations.

There have been some efforts in some regions to overcome this issue through the establishment of a shared job bank in which the temporary labor needs of one employer could be filled by workers who have a medical release for modified duty but their employer cannot accommodate the restrictions for any reason including the economic considerations of small employers.[25] [26] Those past efforts have failed to reach any stage of implementation for a couple of critical reasons:

- The Injured workers' full regular wage may be higher than the rate that an employer seeking temporary labor would pay for the same work in the open market.
- Accepting a worker who is already being treated for a work injury has the potential of increased risk of a second injury which might then

[24] Program Analysis of the TechniGlass Transtional Work Program for 1996 - 2000, including interviews with the on site Program Coordinator for that program.

[25] WorkMed Center for Occupational Health, a division of Allied Services; Scranton, PA. 1993

[26] Occupational Health Link, a division of The Ohio Employee Health Partnership; Columbus, OH. 2000

become the liability of the employer who created the accommodation and accepted the modified duty worker.

There are currently two active programs within Labor and Industries that could be extended to potentially address this issue. The benefits associated with the Loss of Earning Power (LEP) program provides the injured worker who is on modified duty with supplemental compensation if the modified duty placement provides them with wages that are less than 95% of their regular salary.[27] The Preferred Worker Program provides employers who hire workers who are unemployed due to an inability to return to their pre-injury jobs with their former employer with protection against any subsequent work injury claims that might be filed for the first three years that the individual is employed.[28]

It is recommended that Labor and Industries establish a job bank that could be set up and run by the COHE, using the LEP and Preferred Worker Program as a way to address the two primary obstacles. In this model the COHE would establish a pool of employers who occasionally or regularly have the need for temporary labor and would then survey those jobs to establish the functional physical requirements of the jobs. Those jobs could then be accessed for those injured workers whose restrictions can't be accommodated by their regular employer and the COHE could facilitate temporary placement into the position.

The LEP program could be used to insure that the employer accepting the temporary labor would only pay a rate that is equal to some fair market rate or the rate that they pay their own workers for the same labor. Differences between that rate and the workers' regular salary would be made up through the LEP program, protecting the worker from any loss in income. The Preferred Worker Program could be extended to the placement of temporary workers so that the employer providing the temporary job placement is protected from any possible liability associated with secondary injuries that might be incurred during the workers' tenure in the temporary position. If properly implemented, such a program has the potential to benefit many different parties including the injured worker who is able to reap the therapeutic benefits associated with productive work.
Conceptually it will be important that all parties view such a program as another form of a transitional work program. Limitations should be set on the duration of time that a worker can work in a temporary assignment to insure that the worker understands the temporary nature of the work and maintains their vision on the goal of full recovery and return to their pre-injury job duties.

This program could be run directly through Labor and Industries but it is suggested that it should be run by the COHE as part of their care

[27] Doctor's Desk Reference on Early Return to Work for Injured Workers. Published by Washingtdon Department of Labor and Industries.
[28] Information obtained from L&I web page: www.wa.gov/lni/workcomp/prefer.htm

coordination process. Some compensation may be needed to assist the COHE with the administrative functions associated with contacting area employers and establishing the job bank. Ongoing operations can easily be funded through the use of a billing code that the COHE can use each time they successfully place an injured worker into a job through the job bank.

To facilitate this process, the information management systems used by the COHE should have some capability for the functional ratings of jobs and the ability to cross-reference the physical capabilities of an individual against the jobs that are available in the bank. This same tool would be useful in the COHEs role in developing transitional duty programs for employers.

Appendix A[29]

CPT 2001	Description	Time		Reimbursement
99361	Medical Conferences/Team Conference – by a physician with a interdisciplinary team of health professionals or representatives of community agencies to coordinate activities of the patient – patient not present	30 mins		$61.19
99362	Medical Conferences/Team Conference – by a physician with a interdisciplinary team of health professionals or representatives of community agencies to coordinate activities of the patient – patient not present	60 mins		$117.68
99371	Telephone Call – by physician to patient or for consultation or medical management or for coordinating medical management with other health care professionals. Simple or brief			$7.06
99372	Telephone Call – by physician to patient or for consultation or medical management or for coordinating medical management with other health care professionals. Intermediate, to add new therapy to adjust treatment			$14.12
99373	Telephone Call – by physician to patient or for consultation or medical management or for coordinating medical management with other health care professionals. Complex – difficult patient or treatment plan.			$21.18

[29] *State of Washington Department of Labor and Industries,* Medical Aid Rules and Fee Schedules, p. July 1, 2000

APPENDIX B

Performance Indicators Measurement and Payment Form					
Indicator (Definitions Follow)	Benchmark / Target	Current Qtr. Measure	Paid at 100%	Paid at 75%	Paid at 50%
Employer Notification					
Work Restrictions					
Worksite Evaluations					
Access to Care					
Patient Satisfaction					
Employer Satisfaction					
Accurate Billing					
Minimum Education Credits					
Quality Indicators Compliance					

Performance Indicators: Descriptions

1. Employer Notification: As described in the white paper on provider education, the provider should be playing a role in notifying the employer of the treatment of a work injury within 24 hours of treatment. Performance should be measured based upon how many cases are reported within the desired period of time.
2. Work Restrictions: The provider should be providing work restrictions or capabilities at the time of treatment for all cases unless the patient is, in fact, totally disabled. The target should be set based upon historical data reflective of the percentage of cases that can be initially categorized as totally disabled. All others should have some definition of work capacity and providers should be measured against how closely they meet that target percentage.
3. Worksite Evaluations: The provider or some agent of the provider should be conducting evaluations of the job site to determine the risks associated with the job relative to the capabilities of the patient being treated. This indicator may be met through the COHE evaluation of the worksite and the willingness of the provider to use that information in their return to work plan.
4. Access to Care: This indicator refers to how quickly the provider is able to accommodate requests for appointments. It is of most importance for the first visit to evaluate the injury and for the first visit after a referral to a specialist. Delays in these first visits results in increased cost. A target should be set (i.e. specialists will see all referred patients within 5 days of referral) and the providers evaluated against compliance to that target.
5. Patient Satisfaction: Through the use of basic patient satisfaction surveys it should be possible to evaluate the level of satisfaction with each individual provider. Caution must be taken, however, to factor in possible patient discontent due to a disagreement regarding the return to work outcome.
6. Employer Satisfaction: Employers should be periodically surveyed to determine their satisfaction with the overall system. It is likely impractical to survey every employer about every single provider that has provided care to every injured worker. This performance indicator is likely better measured as a group indicator and, as such, is more reflective of the performance of the COHE. However, any specific comments (positive and negative) from employers that are directed to specific providers should not be disregarded.
7. Accurate Billing: Through a basic auditing system, the accuracy of bills from each provider should be evaluated and performance rated based upon the percentage of bills that are submitted without errors.
8. Minimum Education Credits: Education credits should be awarded for active participation in L&I or COHE sponsored or sanctioned educational activities. Providers should be expected to meet some minimum number of credits and their performance measured against

that target. It will be important to understand that providers have many educational demands placed upon them. Whenever possible L&I and the COHE should seek accreditation from professional associations (i.e. AMA) for their programs so that providers may obtain credits that serve a dual purpose. Likewise, courses offered by professional associations that also cover topics relative to the issue of the treatment and rehabilitation of work injury should be considered for sanctioned status by L&I or the COHE and included each provider's total credits.

9. Treatment Guidelines: The provider should be following the quality indicator guidelines as established by the University of Washington research team. Provider performance should be measured against the number or percentage of cases where the quality indicators were not followed and the provider failed to document the justification for the change.

APPENDIX C

Outcomes Analysis Recommendations for COHE Pilot Project

The pilot project will encompass the activities referenced in the white papers. In order to determine the success or failure of the project, a financial analysis should be undertaken. The pilot project will incur additional costs by compensating the COHEs and through the administration of the program, but should result in improved quality of patient care and reduced overall claim costs for both medical and indemnity.

It is recommended that the analysis begin with the implementation of the program. During the research for white paper six, the Actuarial Section of the Department of Labor and Industries provided the paid and incurred loss history for the Accident Fund and the Medical Aid Fund[30]. These losses start with 1970 injuries and end with 2000 injuries. The analysis of the pilot project should include projections of the paid and incurred losses based on the population of employers and claims within the pilot regions. Incurred losses would include items such as rates of injury, rates of re-injury, and duration of time off work due to injury. If there are any program differences between the pilot regions then comparisons between pilot regions should also be made.

Projections of the paid and incurred losses for two to three years into the future should be done before the implementation of the program. Once the program is implemented actual development of incurred and paid losses can be compared to the projections and overall program savings for claims costs can be calculated. Consideration for the calculation of the incurred losses must include but may not be limited to stratification of medical cost inflation adjustments, indemnity benefit changes, and any other system changes that would impact loss projections. Doing this on an average per claim basis will remove from the comparison any claim frequency changes that may occur. Comparisons of the claim costs can be done against; (a) non-pilot regions; (b) pilot to projections; and (c) non-pilot to projections.

The reductions in overall claim costs can then be compared to the costs of administering the program. Those costs should include any administration costs incurred to run the pilot project, the additional fees paid to pilot providers, and the fees paid the COHEs for case coordination.

An additional recommended analysis would include the comparison of average claim costs prior to the pilot project and the average claim cost after the implementation of the pilot project. Certain ICD-9 claims can be identified that would represent the injuries within the pilot region. The

[30] Data provided by the Department of Labor and Industries under a file containing Total and Medical Aid Fund Paid and Incurred Losses and accident Fund Incurred and Paid Losses

average claim costs in other regions for those ICD-9 claims could then be compared to the pilot region. Additional data elements should be considered beyond the ICD-9 code. Manual classification would be the next most important data element, followed by claim type (TT, PTD, Medical, Etc.). The program costs would have to be calculated on a per claim basis as well. The improvement in cost, if any, in individual claims would have to cover the per claim costs of the program. In essence, this would indicate what reduction in the average cost per claim would be needed to pay for the program.

APPENDIX D
SUMMARY OF INCENTIVES

Pilot Provider Incentives

Type	Behavior/Activity	Incentive
Financial	24 Hour Reporting	Billing/Fee Code
Financial	Treatment Summary Form	Billing/Fee Code
Financial	Patient Education	CPT Code
Non-Financial	High Quality Occupational Health Care	Prior Authorization Relief
Non-Financial	Compliance with Communication Requirements	Relief From 60 Day Report

COHE Incentives

Type	Behavior/Activity	Incentive
Financial	Care Coordination	CPT Code
Financial	Outstanding Performance Indicators	CPT Code
Financial	Transitional Work Program	Hourly Rate
Financial	Patient Education	CPT Code
Financial	Job Bank Coordination	Compensation for setup plus CPT Code
Non-Financial	COHE	Community Visibility and Reputation
Non-Financial	COHE	State-Of-The Art Case Management System

Employer Incentives

Type	Behavior/Activity	Incentive
Financial	Transitional Work Program	80% of Development Cost
Direct or Indirect Financial	Participation in Job Bank	Cost Reduction Strategy Improved Outcomes